STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

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F0000	This visit was for a Post Survey Revisit [PSR] to the Recertification and State Licensure Survey completed on 8/12/11. Survey dates: September 26, 27, 2011 Facility number: 000137 Provider number: 155232 AIM: 100266140 Survey team: Ginger McNamee, RN, TC Delinda Easterly, RN Betty Retherford, RN [9/26/11] Karen Lewis, RN [9/26/11] Census bed type: SNF: 9 SNF/NF: 49 TOTAL: 58 Census payor type: Medicare: 9 Medicaid: 49 Total: 58 Sample: 10 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Submission ofi tthis Plan ofi correctton does nott consttttutte an admission tto or an agreementt witth fiactts alleged on tthe survey reportt Submission ofi tthis Plan ofi Correctton does nott consttttutte an admission or an agreementt by tthe provider ofi tthe ttrutth ofi fiactts alleged or correcttons sett fiortth on tthe sttattementt ofi deficiencies. The Plan ofi Correctton is prepared and submitted because ofi requirementts under Sttatte and Federal law. Please acceptt tthis Plan ofi Correctton as our credible allegatton ofi compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 9/29/11 Cathy Emswiller RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F0157	F 157 I. A. The involved nurse who failed to report to the physician the results of the urinalysis for Resident #45 in a timely manner has been addressed and re-educated. Please note that Resident #45 has received necessary treatment in response to the urinalysis result. B. Please note that the	10/11/2011

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			physician of Resident #45 has been notified and clarification orders received in regard to frequency of accuchecks as well as physician call parameters. II. In an effort to identify any other resident affected by a potential delay in physician notification, lab results for labs drawn and/or urinalysis ordered during the prior 30 days as well as auditing of the accucheck orders and compliance therewith for all applicable residents will be conducted. Should concerns be noted, corrective action shall be taken as warranted. As all residents could potentially be affected, the following corrective actions shall be taken: III. As a means to ensure ongoing compliance with reporting to the physician in a timely manner results of lab results (e.g., urinalysis) warranting potential intervention, as well as blood sugars which fall outside parameters set by the physician, directed in-service training will be conducted. Said training will specifically address reporting urinalysis results for residents with a urinary tract infection to the physician in a timely manner and reporting to a physician blood sugars above the parameters set by the physician per the facility's policies and procedures. It will not be acceptable to place lab results which could indicate treatment warranted in the folder of the physician and/or nurse	

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	A. Based on record review and interview, the facility failed to report to the physician results of a urinalysis in a timely manner for 1 of 1 residents reviewed [Resident #45] with a urinary tract infection in a		practitioner to be reviewed on his/her next visit. IV. As a mean of quality assurance, following the aforementioned in-service training, auditing for compliance shall be completed on scheduled days of work by designated administrative/nursing staff. Designated staff shall be educated as to the expectation of thorough monitoring for compliance, not only completion of the task. Should noncompliance be noted, corrective action including re-education and disciplinary action, if warranted, shall be initiated. The assigned nurse consultant/ designee shall be responsible to visit the facility on an, at least, weekly basis to confirm compliance with the reporting of results to the physician in a timely manner (both of labs and of blood sugars which fall outside of pre-determined parameters). Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and potential revision of monitoring, if warranted. Completion Date: 10/11/11	

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	sample of 10. [Resident #45] B. Based on record review and interview, the facility failed to report to the physician blood sugars above the parameters set by the physician for 1 of 5 residents reviewed for blood sugar monitoring in a sample of 10. [Resident #45] Findings include: A. Resident #45's clinical record was reviewed on 9/26/11 at 9:50 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, depression, and anxiety. The resident had a physician telephone order dated 8/30/11, to obtain a urinalysis and culture with sensitivity. The resident had a 9/7/11, order from the Nurse Practitioner for Cipro [an antibiotic] 500 mg two times a day for seven days. Review of nurse progress notes indicated the following: 8/30/11, 2:00 p.m., Nurse Practitioner [NP] notified. Resident presents with confusion and hallucinations. Resident stated this a.m. to "wake me up at 9:00 a.m. tomorrow so I can go to work at [name of company]." The resident stated "I am at [name of hospital] in the mental ward." The resident stated "Sparks are			

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	coming from the wall" and indicated snakes were chasing him. The Nurse Practitioner ordered a urinalysis with a culture and sensitivity to rule out a urinary tract infection [UTI.] 9/6/11, 11:45 p.m., Laboratory called for a request to have the final result of the urinalysis faxed to the facility per request of the day shift nurse as she was unable to call. 9/6/11, 11:57 p.m., Results of urinalysis received and noted. Information to be given to the day shift nurse and the Nurse Practitioner. 9/7/11, 10:00 a.m., Resident seen by Nurse Practitioner and an antibiotic was ordered. Review of a culture and sensitivity report faxed to the facility from the laboratory on 9/4/11 at 10:10 a.m., indicated the urine had Klebsiella Pneumoniae growth count of 60 - 70,000 CFU/ml [colony forming units per milliliter.] During an interview with the Director of Nursing on 9/26/11 at 4:15 p.m., she indicated the 9/4/11 faxed report of the urinalysis was placed in the Nurse Practitioner's folder for her to review on her next visit. B. Resident #45's clinical record was reviewed on 9/26/11 at 9:50 a.m. The			

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	resident's diagnoses included, but were not limited to, diabetes mellitus, depression, and anxiety. The resident's current Physician's Orders for 9/1/11 through 9/30/11 were signed, but not dated by the Physician. The orders indicated the resident was to have accuchecks [blood sugar monitoring] completed four times a day and as needed. The orders indicated the physician was to be notified of blood sugars greater than 250. Review of the "Blood Glucose Monitoring Record" for September, 2011, indicated blood sugars were only checked two times a day at 6:30 a.m. and 4:30 p.m. each day, instead of four times a day as ordered by the physician. The record indicated the following blood sugar results at 4:30 p.m., without the physician being notified. 256 on 9/3/11 280 on 9/5/11 284 on 9/6/11 277 on 9/9/11 310 on 9/10/11 274 on 9/11/11 274 on 9/12/11 277 on 9/14/11 This resulted in the physician not being notified eight times for blood sugars greater than 250 in September, 2011.			

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	The record lack of any indication of the physician being notified of the blood sugars only being done two times a day, instead of the four times a day. Review of the September, 2011, nurses progress notes lacked an indication of the physician being notified of the blood sugars above 250. Review of the daily blood sugar audits, provided by the Administrator on 9/26/11 at 10:00 a.m., indicated Resident #45's blood sugar's were audited on 9/7/11 and 9/22/11 with no problems identified. During an interview with the Nurse Consultant on 9/27/11 at 10:10 a.m., she indicated the physician had not been notified of the blood sugars greater than 250. The current 1/06, "Physician & Family Notification Procedure" was provided by the Director of Nursing on 9/26/11 at 3:40 p.m. The procedure indicated the purpose was to keep the physician apprised of all condition changes. The procedure indicated the physician was to be notified of any changes in condition that may or may not warrant a change in the treatment plan. The procedure indicated thorough and explicit information reported to the physician with the date and time reported			

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	should be included in the nurses notes along with the response from the physician. This federal tag was cited on 8/12/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-5(a)(2) 3.1-5(a)(3)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure the nursing staff correctly transcribed and administered medications for 1 of 3 residents readmitted from the hospital in a sample of 10. (Resident #4) Findings include: The clinical record for Resident #4 was reviewed on 9/26/11 at 12:45 p.m. Diagnoses for Resident #4 included, but were not limited to, hypertension and status post left hip replacement. The clinical record indicated the resident was readmitted to the facility at 10:00	F0282	F 282 I. The physician of Resident #4 has been contacted and clarification orders obtained to ensure that Resident #4 is receiving all medications as prescribed by the attending physician. II. In an effort to identify any other residents who might be affected, those residents who have been re-admitted to the facility within the last 30 days have been identified and re-admission orders reviewed to ensure correct transcription. III. As a means to ensure going compliance with correctly transcribing and administering medications for residents re-admitted to the facility, the following actions shall be taken: Licensed nursing staff shall receive directed in-service	10/11/2011

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	p.m., on 8/30/11, following hospitalization for a left hip fracture. The nurse on duty transcribed the transfer readmission medication orders onto the "Admission Orders and Plan of Care" record and then onto the August 2011 "Medication Administration Record" (MAR). The nurse transcribed four additional medication orders onto the admission order form and the MAR which had not been reordered following the hospital admission. The following four medications were: Rulox (an anti-acid medication) Suspension 30 ml (milliliters) daily. Tramadol (a pain medication) 50 mg (milligrams) daily at bedtime. Ex-lax (a laxative) 1 tablet at bedtime. Propranolol (an anti-hypertensive/anti-anginal medication) 40 mgs twice daily. The August 2011 MAR indicated the following: The Rulox was given at 8:00 a.m. on 8/31/11. The Ex-lax and Tramadol were given at 8:00 p.m. on 8/31/11. The Propranolol medication was given at 8:00 a.m. and 8:00 p.m. on 8/31/11. These medications had been marked out		training addressing the correct transcription and administration of medications following the resident having being re-admitted from the hospital shall be provided. Following said training, the facility will mandate that two licensed nurses review re-admission orders and affirm correct transcription of said orders. IV. As a means of quality assurance, the Director of Nursing/designee shall be responsible to review the orders of any newly re-admitted resident on his/her first day of work following resident re-admission. Should a concern be noted with the transcription of re-admission orders, the involved nurse(s) shall be re-educated and disciplinary action taken, if warranted. Further, the assigned nurse consultant/designee shall be responsible to visit the facility on an, at least, weekly basis and review the orders of a resident newly admitted to confirm continued compliance with the above plan of correction. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted. Completion Date: 10/11/11	

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	on the September 2011 MAR and "not an order" was written by the name of the medication. During an interview on 9/26/11 at 2:25 p.m., the Assistant Director of Nursing indicated the nurse on duty had put the four orders noted above on the admission order form in error. She indicated the resident had previously been on these medications, but they had not been reordered on 8/30/11 and should not have been included on the re-admission order form. She indicated these four medications were given in error on 8/31/11. This federal tag was cited on 8/12/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(g)(2)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure blood sugar	F0309	F 309 I. (1) Please note that the physician of Resident #45 has been notified and clarification	10/11/2011

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	monitoring and/or sliding scale insulin coverage was provided as ordered by the physician for 3 of 5 residents reviewed in a sample of 10. [Resident #'s 45, 13, 12] Findings include: 1. Resident #45's clinical record was reviewed on 9/26/11 at 9:50 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, depression, and anxiety. The resident's current Physician's Orders for 9/1/11 through 9/30/11 were signed, but not dated by the Physician. The orders indicated the resident was to have accuchecks [blood sugar monitoring] completed four times a day and as needed. Review of the "Blood Glucose Monitoring Record" for September, 2011, indicated blood sugars were only checked two times a day at 6:30 a.m. and 4:30 p.m. each day, instead of four times a day as ordered by the physician. This resulted in the resident not receiving blood sugar monitoring as order 50 times in September, 2011. Review of the daily blood sugar audits, provided by the Administrator on 9/26/11 at 10:00 a.m., indicated Resident #45's blood sugar's were audited on 9/7/11 and		orders received in regard to frequency of accuchecks as well as blood sugar call parameters. (2) The physician of Resident #13 was addressed in regard to omitted blood sugars as well as incorrect coverage administered. Involved nurses were re-educated. (3) The physician of Resident #12 was addressed in regard to incorrect coverage administered. Involved nurses were re-educated. II. In an effort to identify any other resident affected by blood sugars not conducted at the ordered frequency and/or receiving inaccurate coverage, all applicable diabetic residents were identified and blood sugars/coverage performed within the last 30 days will conducted. Should concerns be noted, corrective action shall be taken as warranted. As all residents could potentially be affected, the following corrective actions shall be taken: III. As a means to ensure ongoing compliance with ensuring blood sugar monitoring and/or sliding scale coverage is provided as ordered by the physician, directed in-service training will be conducted. Said training will specifically address the aforementioned concerns. IV. As a mean of quality assurance, following aforementioned in-service training, auditing for compliance shall be completed on scheduled days of work by	

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	9/22/11 with no problems identified. During an interview with the Director of Nursing on 9/26/11 at 4:15 p.m., she indicated she thought the resident's blood sugar order had been changed to being checked two times a day. 2. The clinical record for Resident #13 was reviewed on 9/26/11 at 11:00 a.m. Resident #13's current diagnoses included, but were not limited to, type 2 diabetes mellitus and morbid obesity Resident #13 had a healthcare plan, dated 8/10/11 which indicated the resident had a problem listed as, the resident has a diagnosis of diabetes mellitus and is at risk for experiencing hypo or		designated administrative/nursing staff. Designated staff shall be addressed in regard to thorough monitoring for compliance with the orders; not just completion of the task. Should noncompliance be noted, corrective action including re-education and disciplinary action, if warranted, shall be implemented. The assigned nurse consultant/ designee shall be responsible to visit the facility on an, at least , weekly basis to confirm compliance with adherence to conducting blood sugars and provision of sliding scale coverage as per physician's orders. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted. Completion Date: 10/11/11	

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	hyperglycemia. Interventions for this problem included, monitor blood sugars as ordered and administer sliding scale insulin as ordered. Resident #13 had current physician's orders for the following, A. Monitor blood sugar levels 4 times daily. B. Administer Novolog insulin 40 units subcutaneously three times daily. C. Administer Levemir insulin 72 units subcutaneously every morning and evening. D. Administer Novolog insulin according to blood sugar results using sliding scale below 151 - 200 = 6 units 201- 250 = 10 units 251 - 300 = 14 units 301 - 350 = 20 units 315 - 400 = 24 units greater than 400 = 28 units			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The original date of all the above orders was 2/3/11. Review of the September 2011 "Blood Glucose Monitoring Record" for Resident #13 indicated on the following dates and times the resident did not have blood sugar levels monitored and or receive sliding scale insulin coverage as ordered by the physician, A. 9/1/11 at 4:30 p.m., the blood sugar result was 190. The resident did not receive any insulin coverage. The resident should have received 6 units. B. 9/1/11 at 9:00 p.m., the blood sugar was 183. The resident did not receive any insulin coverage. The resident should have received 6 units. C. 9/19/11 at 4:30 p.m., no blood sugar result was documented as having been completed. D. 9/24/11 at 4:30 p.m., no blood sugar result was documented as having been completed. During an interview with LPN #1 on 9/26/11 at 11:20 a.m. she indicated the nursing staff were to document blood sugar results and sliding scale insulin on the "Blood Glucose Monitoring Record."			

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	155232	A. BUILDING 00 B. WING	09/27/2011

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	She further indicated this was the only place in the resident's medical record where blood sugar results and sliding scale insulin were to be documented. 3. The clinical record for Resident #12 was reviewed on 9/26/11 at 9:51 a.m. Diagnoses for Resident #12 included, but were not limited to, diabetes mellitus and diabetic neuropathy. Current physician orders for Resident #12, signed 8/10/11, included, but were not limited to, Novolog insulin 100 units per milliliter (ml) to be given subcutaneously for the following blood sugar ranges: 100 - 150 give 3 units 151 - 200 give 6 units 201 - 250 give 10 units 251 - 300 give 15 units greater than 300 give 20 units. Review of the September, 2011, Medication Administration Record (MAR) indicated on the following dates and times Resident #12 had her blood sugar monitored as ordered and received the incorrect sliding scale insulin dose: 9/1/11 at 8 a.m., the blood sugar result was documented as 130, no sliding scale insulin was given. The resident should have received 3 units.			

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	9/3/11 the blood sugar was 120 at 8 a.m., no sliding scale insulin was given. The resident should have received 3 units. 9/3/11 the blood sugar was 144 at 4 p.m., no sliding scale insulin was given. The resident should have received 3 units. 9/4/11 the blood sugar was 108 at 4 p.m., no sliding scale insulin was given. The resident should have received 3 units. 9/6/11 the blood sugar was 107 at 8 a.m., no sliding scale insulin was given. The resident should have received 3 units. 9/7/11 the blood sugar was 124 at 8 a.m., no sliding scale insulin was given. The resident should have received 3 units. 9/7/11 the blood sugar was 121 at 4 p.m., no sliding scale insulin was given. The resident should have received 3 units. 9/8/11 the blood sugar was 130 at 4 p.m., no sliding scale insulin was given. The resident should have received 3 units. 9/21/11 the blood sugar was 111 at 8 a.m., no sliding scale insulin was given. The resident should have received 3 units. During an interview with the DoN on 9/26/11 at 2:45 p.m., she indicated all			

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	audit information related to insulin sliding scale coverage had been provided. The provided audit records lacked any information related to auditing having been completed for Resident #12. This federal tag was cited on 8/12/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-37(a)			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F0315	F 315 I. The involved nurse who failed to report to the physician the results of the urinalysis for Resident #45 in a timely manner was addressed. Please note that Resident #45 has received	10/11/2011

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			necessary treatment in response to the urinalysis result. II. In an effort to identify any other resident affected by delay in physician notification, lab results for the prior 30 days will be conducted. Should concerns be noted, corrective action shall be taken as warranted. As all residents could potentially be affected, the following corrective actions shall be taken: III. As a means to ensure ongoing compliance with reporting to the physician in a timely manner results of lab results (e.g., urinalysis) warranting potential intervention, directed in-service training will be conducted. Said training will specifically address reporting urinalysis results for residents with a urinary tract infection to the physician in a timely manner and prohibition of placing a result warranting potential treatment in the folder of the physician/nurse practitioner for review at the time of his/her next facility visit. IV. As a mean of quality assurance, following aforementioned in-service training, auditing for compliance shall be completed on scheduled days of work by designated administrative/nursing staff. Should noncompliance be noted, corrective action including re-education and disciplinary action, if warranted, shall be implemented. The assigned nurse consultant/ designee shall be responsible to visit the facility on an, at least, weekly basis to	

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	Based on record review and interview, the facility failed to obtain and report results of a urine specimen in a timely manner for 1 of 1 residents reviewed with a urinary tract infection in a sample of 10. [Resident #45] Findings include: 1. Resident #45's clinical record was reviewed on 9/26/11 at 9:50 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, depression, and anxiety. The resident had a physician telephone order dated 8/30/11, to obtain a urinalysis and culture with sensitivity. The resident had a 9/7/11, order from the Nurse Practitioner for Cipro [an antibiotic] 500 mg two times a day for seven days. Review of nurse progress notes indicated the following: 8/30/11, 1:00 a.m., The resident was		confirm compliance with the reporting of results to the physician in a timely manner. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted. Completion Date: 10/11/11	

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	resting easy with no complaint of discomfort or injury from fall. 8/30/11, 2:00 p.m., Nurse Practitioner [NP] notified. Resident presents with confusion and hallucinations. Resident stated this a.m. to "wake me up at 9:00 a.m. tomorrow so I can go to work at [name of company.]" The resident stated "I am at [name of hospital] in the mental ward." The resident stated "Sparks are coming from the wall" and indicated snakes were chasing him. The Nurse Practitioner ordered a urinalysis with a culture and sensitivity to rule out a urinary tract infection [UTI.] 8/31/11, 5:30 a.m., Unable to obtain urinalysis this shift, but information will be passed on to day shift of needing a sample. 9/1/11, 2:15 p.m., urine collect and laboratory to pick up the specimen on 9/2/11. 9/6/11, 11:45 p.m., Laboratory called for a request to have the final result of the urinalysis faxed to the facility per request of the day shift nurse as she was unable to call. 9/6/11, 11:57 p.m., Results of urinalysis received and noted. Information to be given to the day shift nurse and the Nurse Practitioner. 9/7/11, 10:00 a.m., Resident seen by Nurse Practitioner and an antibiotic was ordered.			

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	Review of a culture and sensitivity report faxed to the facility from the laboratory on 9/4/11 at 10:10 a.m., indicated the urine had Klebsiella Pneumoniae growth count of 60 - 70,000 CFU/ml [colony forming units per milliliter.] During an interview with the Director of Nursing on 9/26/11 at 4:15 p.m., she indicated the 9/4/11 faxed report of the urinalysis was placed in the Nurse Practitioner's folder for her to review on her next visit. The current 1/06, "Physician & Family Notification Procedure" was provided by the Director of Nursing on 9/26/11 at 3:40 p.m. The procedure indicated the purpose was to keep the physician apprised of all condition changes. The procedure indicated the physician was to be notified of any changes in condition that may or may not warrant a change in the treatment plan. This federal tag was cited on 8/12/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-41(a)(2)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, record review and interview, the facility failed to ensure narcotic pain medications were correctly signed out and documented as having been administered for 1 of 3 residents reviewed with physician's orders for narcotic pain medication in a sample of 10. (Resident #13) Findings include: The clinical record for Resident #13 was	F0329	F 329 I. Resident #13 was provided narcotic pain medication as per order. The licensed staff member who failed to correctly sign out and document the administration of the medication has been addressed. II. In an effort to identify any other concerns regarding incorrect signing/ documentation of narcotics, narcotic count sheets have been reviewed/compared to the PRN flowsheets in an effort to identify further concerns with thorough documentation. As all	10/11/2011

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	reviewed on 9/26/11 at 11:00 a.m. Resident #13's current diagnoses included, but were not limited to, type 2 diabetes mellitus and morbid obesity Resident #13 had a healthcare plan, dated 8/25/11 which indicated the resident had a problem listed as, the resident has the potential for pain related to history of fracture and morbid obesity. Interventions for this problem included, administer pain medication as ordered, and monitor pain medication for effectiveness. Resident #13 had a current physician's order for hydrocodone 10-325 (a narcotic pain medication), 1 tablet orally every 4 hours PRN (as needed) for pain. The original date of this order was 5/4/11. During observation on 9/26/11 at 9:40 a.m. LPN #1 administered hydrocodone 10 - 325 1 tablet to Resident #13. During an interview with LPN #1 on 9/26/11 at 9:40 a.m., she indicated any time a resident received a PRN medication the nursing staff were supposed to document the medication on the "PRN Medication Flow Sheet." and sign the medication out on the "Controlled Drug Record.." LPN #1 signed the		residents could be affected, the following corrective actions have been taken: III. As a means to ensure ongoing compliance with ensuring narcotic pain medications are correctly signed and documented as having been administered, directed in-service training will be provided specifically addressing the correct signing out and documentation of administering narcotic medications on the PRN flowsheet as per order. Following said in-service training, administrative nursing staff will be assigned to audit the narcotic records and compare to the resident specific documentation (i.e., PRN flowsheet) on scheduled days of work to ensure ongoing compliance with the correct signing and documenting of narcotic medication administration. Should noncompliance be noted, re-education and disciplinary action shall be implemented, if warranted. IV. As a means of quality assurance, the assigned nurse consultant/designee shall conduct, at least, weekly visits and review the narcotic records and corresponding PRN flowsheets to ensure compliance with correct signing and documenting of narcotic medication upon administration. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee	

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	medication out on the "Controlled Drug Record" and then documented she administered the medication on the flow sheet. The entry on the "PRN Medication Flow Sheet" was the last entry on the flow sheet. A copy of the September 2011 "PRN Medication Flow Sheet" and the "Controlled Drug Record" for Resident #13 were requested on 9/26/11 at 12:45 p.m. A copy of the "PRN Medication Flow Sheet" and the "Controlled Drug Record" were provided by the RN consultant on 9/26/11 at 1:00 p.m. The September 2011, "PRN Medication Flow Sheet" and "Controlled Drug Record" for Resident #13 were reviewed on 9/26/11 at 2:00 p.m. The "Controlled Drug Record" had the PRN hydrocodone medication signed out by nursing staff on 9/5/11 at 11:00 p.m., 9/6/11 at 4:00 p.m. and 9/22/11 at 11:00 a.m. The "PRN Medication Flow Sheet" did not have any entry which indicated Resident #13 had received the as needed hydrocodone pain medication. During an interview with the Director of Nursing on 9/26/11 at 9:00 a.m. she indicated the nursing staff were to		on a quarterly basis for review and recommended revision of monitoring, if warranted. Completion Date: 10/11/11	

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	document any PRN medications they administered on the "PRN Medication Flow Sheet" and sign out the medication. She further indicated the flow sheet was the only place in the medical record where the nurses documented PRN medications. She indicated the PRN flow sheet and the sign out sheets for the medications should match. She indicated she had no explanation as to why the nurses did not document they had given the PRN hydrocodone medication on the flow sheet. This federal tag was cited on 8/12/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-48(a)			
F0428 SS=D	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on record review and interview, the facility failed to ensure the pharmacy consultant reviewed the PRN narcotic pain medication records for 1 of 3	F0428	F 428 I. Resident #13 was provided narcotic pain medication as per order. The licensed staff member who failed to correctly sign out and document the	10/11/2011

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	residents reviewed with physician's orders for pain medications in a sample of 10. (Resident #13) Findings include: The clinical record for Resident #13 was reviewed on 9/26/11 at 11:00 a.m. Resident #13's current diagnoses included, but were not limited to, type 2 diabetes mellitus and morbid obesity Resident #13 had a healthcare plan, dated 8/25/11 which indicated the resident had a problem listed as, the resident has the potential for pain related to history of fracture and morbid obesity. Intervention for this problem included, administer pain medication as ordered, and monitor pain medication for effectiveness. Resident #13 had a current physician's order for hydrocodone 10-325 (a narcotic pain medication), 1 tablet orally every 4 hours as needed for pain. the original date of this order was 5/4/11. During observation on 9/26/11 at 9:40 a.m. LPN #1 administered hydrocodone 10 - 325 1 tablet to Resident #13. During an interview with LPN #1 on 9/26/11 at 9:40 a.m. she indicated any		administration of the medication has been addressed. Discussion has been held with the consultant pharmacist as to necessary documentation in regard to narcotic administration. II. As all residents receiving PRN narcotics could be affected, the following corrective actions have been taken: III. As a means to ensure ongoing compliance with ensuring the consultant pharmacist review includes assessing narcotic pain medication administration for correct signing and documentation of the medication being administered, directed in-service training will be provided specifically addressing the correct signing out and documentation of administering narcotic medications as per order, as well as necessary consultant pharmacist review for compliance. Following said in-service training, administrative/nursing staff will be assigned to audit the narcotic records and compare to the resident-specific documentation (i.e., PRN flowsheet) to ensure ongoing compliance with the correct signing and documenting of narcotic medication administration. Should noncompliance be noted, corrective action/ disciplinary re-education shall be conducted as warranted. Additionally, the DON shall be responsible to monitor the consultant pharmacist monthly review for evidence of	

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	time a resident received a PRN medication the nursing staff were supposed to document the medication on the "PRN Medication Flow Sheet." and sign the medication out on the "Controlled Drug Record.." LPN #1 signed the medication out on the "Controlled Drug Record" and then documented she administered the medication on the flow sheet. The entry on the "PRN Medication Flow Sheet" was the last entry on the flow sheet. A copy of the September 2011 "PRN Medication Flow Sheet" and the "Controlled Drug Record" for Resident #13 were requested on 9/26/11 at 12:45 p.m. A copy of the "PRN Medication Flow Sheet" and the "Controlled Drug Record" was provided by the RN consultant on 9/26/11 at 1:00 p.m. The September 2011, "PRN Medication Flow Sheet" and "Controlled Drug Record" for Resident #13 were reviewed on 9/26/11 at 2:00 p.m. The "Controlled Drug Record" had the PRN hydrocodone medication signed out by nursing staff on 9/5/11 at 11:00 p.m., and 9/6 /11 at 4:00 p.m. The "PRN Medication Flow Sheet" did not have any entry which indicated Resident #13 had received the as needed		ongoing monitoring of correct narcotic administration as conducted by the consultant pharmacist. IV. As a means of quality assurance, the assigned nurse consultant/designee shall conduct, at least, weekly visits and review the narcotic records to ensure compliance with correct signing and documenting of narcotic medication upon administration, as well as consultant pharmacist reports for evidence of continued monitoring of the same. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and potential revision of monitoring, as warranted. Completion Date: 10/11/11	

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	hydrocodone pain medication. During an interview with the Director of Nursing on 9/26/11 at 9:00 a.m. she indicated the nursing staff were to document any PRN medications they administered on the "PRN Medication Flow Sheet" and sign out the medication. She further indicated the flow sheet was the only place in the medical record the nurses documented PRN medications. She indicated the PRN flow sheet and the sign out sheets for the medications should match. The clinical record indicated the Facility Consultant Pharmacist was in the facility and reviewed Resident #13's clinical record on 9/14/11. The Pharmacist did not make any notes in the clinical record which would indicate he noted the differences between the "PRN Medication Flow Sheet" and the "Controlled Drug Record". This federal tag was cited on 8/12/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-25(h)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure narcotic pain medications were documented correctly in the clinical record for 1 of 3 residents reviewed with physician's orders for narcotic pain medication in a sample of 10. (Resident #13) Findings include: The clinical record for Resident #13 was reviewed on 9/26/11 at 11:00 a.m. Resident #13's current diagnoses included, but were not limited to, type 2 diabetes mellitus and morbid obesity Resident #13 had a healthcare plan, dated 8/25/11 which indicated the resident had a problem listed as, the resident has the potential for pain related to history of fracture and morbid obesity. Interventions for this problem included,	F0514	F 514 I. Resident #13 was provided narcotic pain medication as per order. The licensed staff member who failed to correctly sign out and document the administration of the medication has been addressed. II. As all residents receiving narcotic medication(s) could be affected, the following corrective actions have been taken: III. As a means to ensure ongoing compliance with ensuring narcotic pain medications are correctly signed and documented as having been administered, directed in-service training will be provided specifically addressing the correct signing out and documentation of administering narcotic medications as per order. Following said in-service training, administrative/nursing staff will be assigned to audit the narcotic records on scheduled days of work and compare to the resident-specific documentation (PRN flowsheet) to ensure ongoing compliance with the	10/11/2011

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	administer pain medication as ordered , and monitor pain medication for effectiveness. Resident #13 had a current physician's order for hydrocodone 10-325 (a narcotic pain medication), 1 tablet orally every 4 hours PRN (as needed) for pain. The original date of this order was 5/4/11. During observation on 9/26/11 at 9:40 a.m. LPN #1 administered hydrocodone 10 - 325 1 tablet to Resident #13. During an interview with LPN #1 on 9/26/11 at 9:40 a.m. she indicated any time a resident received a PRN medication the nursing staff were supposed to document the medication on the "PRN Medication Flow Sheet." and sign the medication out on the "Controlled Drug Record.." LPN #1 signed the medication out on the "Controlled Drug Record" and then documented she administered the medication on the flow sheet. The entry on the "PRN Medication Flow Sheet" was the last entry on the flow sheet. A copy of the September 2011 "PRN Medication Flow Sheet" and the "Controlled Drug Record" for Resident #13 was requested on 9/26/11 at 12:45 p.m.		correct signing and documenting of narcotic medication administration. Should noncompliance be noted, re-education and/or disciplinary action shall be implemented, as warranted. IV. As a means of quality assurance, the assigned nurse consultant/designee shall conduct, at least, weekly visits and review the narcotic records to ensure compliance with the correct signing and documenting of narcotic medication upon administration. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and potential revision of monitoring, if warranted. Completion Date: 10/11/11	

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	A copy of the "PRN Medication Flow Sheet" and the "Controlled Drug Record" was provided by the RN consultant on 9/26/11 at 1:00 p.m. The September 2011, "PRN Medication Flow Sheet" and "Controlled Drug Record" for Resident #13 were reviewed on 9/26/11 at 2:00 p.m. The "Controlled Drug Record" had the PRN hydrocodone medication signed out by nursing staff on 9/5/11 at 11:00 p.m., 9/6/11 at 4:00 p.m. and 9/22/11 at 11:00 a.m. The "PRN Medication Flow Sheet" did not have any entry which indicated Resident #13 had received the as needed hydrocodone pain medication. The copy of the "PRN Medication Flow Sheet" for Resident #13 which was provided by the RN consultant had 4 entries of PRN medications listed below the 9/26/11 entry made by LPN #1 during the observation on 9/26/11 at 9:40 a.m.. The 4 entries indicated Resident #13 had received the PRN hydrocodone medication on 9/12/11 at 3:00 p.m., 9/16/11 at 12:10 a.m., 9/19/11 at 1:15 p.m. and 9/20/11 at 2:00 p.m. During an interview with the Director of Nursing on 9/26/11 at 3:10 p.m. additional information was requested			

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	related to the differences in the "PRN Medication Flow Sheet". During an interview with the Assistant Director of Nursing on 9/26/11 at 3:40 p.m. she indicated she had made the entries on the "PRN Medication Flow Sheet" after the records were requested and facility had noted the differences. She indicated she had spoken to the nurses working on the dates noted above and they indicated they had given the PRN medication to Resident #13. She indicated she should have made the entries a "late entries" and she did not do so. During an interview with the Director of Nursing on 9/27/11 at 9:00 a.m. she indicated the nursing staff were to document any PRN medications they administered on the "PRN Medication Flow Sheet" and sign out the medication. She further indicated the flow sheet was the only place in the medical record the nurses documented PRN medications. She indicated the PRN flow sheet and the sign out sheets for the medications should match. This federal tag was cited on 8/12/11. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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	3.1-50(a)(1) 3.1-50(a)(2)			